

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0046169</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lakewood Nursing & Rehab Center, Llc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1112 North Eastern Avenue</u> <u>Plainfield</u> <u>60544</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Will</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(815) 436-3400</u> Fax # <u>(815) 436-1357</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Edward N. Slack, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>300124869001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>02/01/03</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>31,062</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>31,062</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,792</u>	<u>14,449</u>	<u>5,269</u>	<u>29,510</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,792</u>	<u>14,449</u>	<u>5,269</u>	<u>29,510</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.00%

D. How many bed-hold days during this year were paid by Public Aid?

49 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/1/03

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/1/03 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 93 and days of care provided 4,694Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	175,217	13,283	4,811	193,311		193,311	644	193,955		1
2	Food Purchase		133,557		133,557		133,557	(395)	133,162		2
3	Housekeeping	89,926	36,082		126,008		126,008	(2,416)	123,592		3
4	Laundry	35,869	45,470		81,339		81,339	(4,181)	77,158		4
5	Heat and Other Utilities			85,021	85,021		85,021	773	85,794		5
6	Maintenance	66,122		46,002	112,124		112,124	1,460	113,584		6
7	Other (specify):*							607	607		7
8	TOTAL General Services	367,134	228,392	135,834	731,360		731,360	(3,508)	727,852		8
	B. Health Care and Programs										
9	Medical Director			9,700	9,700		9,700		9,700		9
10	Nursing and Medical Records	1,582,833	57,392	13,613	1,653,838		1,653,838	(9,019)	1,644,819		10
10a	Therapy	76,437	7,709	575	84,721		84,721	264	84,985		10a
11	Activities	59,666	16,230	384	76,280		76,280	14	76,294		11
12	Social Services	78,700		3,947	82,647		82,647	4,310	86,957		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							2,182	2,182		15
16	TOTAL Health Care and Programs	1,797,636	81,331	28,219	1,907,186		1,907,186	(2,249)	1,904,937		16
	C. General Administration										
17	Administrative	75,837			75,837		75,837	5,644	81,481		17
18	Directors Fees										18
19	Professional Services			103,316	103,316		103,316	(70,549)	32,767		19
20	Dues, Fees, Subscriptions & Promotions			17,400	17,400		17,400	(9,734)	7,666		20
21	Clerical & General Office Expenses	56,798	20,290	80,842	157,930		157,930	16,991	174,921		21
22	Employee Benefits & Payroll Taxes			390,690	390,690		390,690	(3,914)	386,776		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,159	1,159		1,159	393	1,552		24
25	Other Admin. Staff Transportation			1,366	1,366		1,366		1,366		25
26	Insurance-Prop.Liab.Malpractice			81,203	81,203		81,203	639	81,842		26
27	Other (specify):*							8,650	8,650		27
28	TOTAL General Administration	132,635	20,290	675,976	828,901		828,901	(51,880)	777,021		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,297,405	330,013	840,029	3,467,447		3,467,447	(57,637)	3,409,810		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc #0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			10,028	10,028		10,028	58,033	68,061			30
31	Amortization of Pre-Op. & Org.			8,013	8,013		8,013	2,110	10,123			31
32	Interest			6,562	6,562		6,562	100,187	106,749			32
33	Real Estate Taxes			47,813	47,813		47,813	(2,239)	45,574			33
34	Rent-Facility & Grounds			249,632	249,632		249,632	(247,029)	2,603			34
35	Rent-Equipment & Vehicles			8,018	8,018		8,018	903	8,921			35
36	Other (specify):*											36
37	TOTAL Ownership			330,066	330,066		330,066	(88,035)	242,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		232,605	352,348	584,953		584,953	(4,200)	580,753			39
40	Barber and Beauty Shops			25,949	25,949		25,949	(25,949)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,594	46,594		46,594		46,594			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		232,605	424,891	657,496		657,496	(30,149)	627,347			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,297,405	562,618	1,594,986	4,455,009		4,455,009	(175,821)	4,279,188			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Lakewood Nursing & Rehab Center, LLC

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,487)	30		9
10	Interest and Other Investment Income	(2,379)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(643)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,600)	21		24
25	Fund Raising, Advertising and Promotional	(10,327)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(69,731)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,167)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,653)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,653)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (175,821)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
Lakewood Nursing & Rehab Center, LLC		
ID# 0044103		
Report Period Beginning:	02/01/03	
Ending:	12/31/03	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1		1
2		2
3		3
4		4
5		5
6		6
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10		10
11		11
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99		99
100		100
101		101
Total	(69,731)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning:

02/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			26		1,687	(504)		(565)				644	1
2	Food Purchase	(643)		(45)			293						(395)	2
3	Housekeeping					485			(2,901)				(2,416)	3
4	Laundry								(4,181)				(4,181)	4
5	Heat and Other Utilities			773									773	5
6	Maintenance	(599)		807	3	1,774			(525)				1,460	6
7	Other (specify):*				107	489	11						607	7
8	TOTAL General Services	(1,242)		1,561	110	4,435	(200)		(8,172)				(3,508)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,096)		102	(3,855)	5,602			(7,772)				(9,019)	10
10a	Therapy				2	262							264	10a
11	Activities			14									14	11
12	Social Services				4,232	78							4,310	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				1,459	723							2,182	15
16	TOTAL Health Care and Programs	(3,096)		116	1,838	6,665			(7,772)				(2,249)	16
	C. General Administration													
17	Administrative					5,636	8						5,644	17
18	Directors Fees													18
19	Professional Services	(491)		(70,060)			2						(70,549)	19
20	Fees, Subscriptions & Promotions	(10,327)		592			1						(9,734)	20
21	Clerical & General Office Expenses	(48,228)	695	8,597		55,911	16						16,991	21
22	Employee Benefits & Payroll Taxes				(3,000)			(631)	(282)				(3,914)	22
23	Inservice Training & Education													23
24	Travel and Seminar			372			21						393	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			639									639	26
27	Other (specify):*				1,045	7,605							8,650	27
28	TOTAL General Administration	(59,046)	695	(59,860)	(1,955)	69,152	48	(631)	(282)				(51,880)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,384)	695	(58,183)	(7)	80,252	(152)	(631)	(16,226)				(57,637)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,487)	61,404	4,116									58,033	30
31	Amortization of Pre-Op. & Org.	(30,968)	33,078										2,110	31
32	Interest	(2,379)	94,464	8,102									100,187	32
33	Real Estate Taxes		(3,387)	1,148									(2,239)	33
34	Rent-Facility & Grounds		(248,930)	1,901									(247,029)	34
35	Rent-Equipment & Vehicles			899			4						903	35
36	Other (specify):*													36
37	TOTAL Ownership	(40,834)	(63,371)	16,166			4						(88,035)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(4,200)				(4,200)	39
40	Barber and Beauty Shops	(25,949)											(25,949)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(25,949)							(4,200)				(30,149)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(130,167)	(62,676)	(42,017)	(7)	80,252	(148)	(631)	(20,426)				(175,821)	45

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning:

02/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Lakewood Plainfield Property LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 248,930	Lakewood Plainfield Property LLC		\$	(248,930)	1
2	V	33 Real Estate Tax	47,812			44,425	(3,387)	2
3	V	32 Interest				94,464	94,464	3
4	V	21 Bank Charges				695	695	4
5	V	30 Depreciation				61,404	61,404	5
6	V	31 Amortization				33,078	33,078	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 296,742			\$ 234,066	\$ * (62,676)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 26	\$ 26
16	V	05 Utilities		Care Centers, Inc.	100.00%	773	773
17	V	06 Maintenance		Care Centers, Inc.	100.00%	807	807
18	V	10 Nursing	15	Care Centers, Inc.	100.00%	117	102
19	V	11 Activities		Care Centers, Inc.	100.00%	14	14
20	V	19 Professional Fees	75,228	Care Centers, Inc.	100.00%	5,168	(70,060)
21	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	592	592
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	8,597	8,597
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	372	372
24	V	26 Insurance		Care Centers, Inc.	100.00%	639	639
25	V	30 Depreciation		Care Centers, Inc.	100.00%	4,116	4,116
26	V	32 Interest		Care Centers, Inc.	100.00%	8,102	8,102
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,148	1,148
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	1,901	1,901
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	899	899
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%		
31	V	02 Food	45	Care Centers, Inc.	100.00%		(45)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 75,288			\$ 33,271	\$ * (42,017)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 812	Care Centers, Inc.	100.00%	\$ 815	\$ 3	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	107	107	16
17	V	10 Nursing Salary	7,383	Care Centers, Inc.	100.00%	3,528	(3,855)	17
18	V	10a Rehab Salary	575	Care Centers, Inc.	100.00%	577	2	18
19	V	11 Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12 Social Service Salary	3,548	Care Centers, Inc.	100.00%	7,780	4,232	20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,459	1,459	21
22	V	17 Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21 Office Salary	7,681	Care Centers, Inc.	100.00%	7,681		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	1,045	1,045	24
25	V	22 Employee Benefits	3,000	Care Centers, Inc.	100.00%		(3,000)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 22,999			\$ 22,992	\$ * (7)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary Salary	\$	Care Centers, Inc.	100.00%	\$ 1,687	\$ 1,687
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%	485	485
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	1,774	1,774
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	489	489
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	5,602	5,602
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	262	262
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	78	78
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	723	723
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	5,636	5,636
24	V	21 Office Salary		Care Centers, Inc.	100.00%	55,911	55,911
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	7,605	7,605
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 80,252	\$ * 80,252

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 627	Care Centers, Inc. - Health Systems Division	100.00%	\$ 42	\$ (585)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	293	293
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%		
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	8	8
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	2	2
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	1	1
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	16	16
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	21	21
23	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%		
24	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	4	4
25	V	39 Ancillary Enteral Supplies		Care Centers, Inc. - Health Systems Division	100.00%		
26	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	81	81
27	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	11	11
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 627			\$ 479	\$ * (148)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 149,712	\$ 149,712	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	150,344	CCS EMPLOYEE BENEFIT GROUP	100.00%		(150,344)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 150,344			\$ 149,712	\$ * (631)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 DIETARY	\$ 4,293	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 3,728	\$ (565)
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING	22,040	XCEL MEDICAL SUPPLY, LLC	100.00%	19,139	(2,901)
18	V	04 LAUNDRY	31,761	XCEL MEDICAL SUPPLY, LLC	100.00%	27,580	(4,181)
19	V	06 REPAIRS & MAINTENANCE	3,990	XCEL MEDICAL SUPPLY, LLC	100.00%	3,464	(525)
20	V	10 NURSING	59,043	XCEL MEDICAL SUPPLY, LLC	100.00%	51,271	(7,772)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS	2,146	XCEL MEDICAL SUPPLY, LLC	100.00%	1,864	(282)
25	V	39 ANCILLARY	31,909	XCEL MEDICAL SUPPLY, LLC	100.00%	27,709	(4,200)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 155,180			\$ 134,754	\$ * (20,426)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.63	1.15%		\$		1
2	Adam Vales	Owner	Clerical	11.00%	See Attached	0.77	1.93%	CCS-VEBA	599	22-7	2
3	Mark Steinberg	Relative	Administrative	0	See Attached	0.99	1.96%	CCI-salary	782	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,381		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	\$ 1,527	\$ 29,510	\$ 26	1
2	05	Utilities	Patient Days	1,764,895	42	46,229	29,510	773	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251	29,510	807	3
4	10	Nursing	Patient Days	1,764,895	42	7,018	29,510	117	4
5	11	Activities	Patient Days	1,764,895	42	838	29,510	14	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074	29,510	5,168	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428	29,510	592	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091	29,510	8,597	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233	29,510	372	9
10	26	Insurance	Patient Days	1,764,895	42	38,230	29,510	639	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194	29,510	4,116	11
12	32	Interest	Patient Days	1,764,895	42	484,531	29,510	8,102	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681	29,510	1,148	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677	29,510	1,901	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777	29,510	899	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,998,780	\$		\$ 33,271	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			213,393	213,393		815	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			26,918			107	2
3	10 Nursing Salary	Direct Cost			976,718	976,718		3,528	3
4	10a Rehab Salary	Direct Cost			103,898	103,898		577	4
5	11 Activity Salary	Direct Cost			10,902	10,902			5
6	12 Social Service Salary	Direct Cost			306,863	306,863		7,780	6
7	15 Emp. Ben. - Healthcare	Direct Cost			174,348			1,459	7
8	17 Administration Salary	Direct Cost			1,191,200	1,191,200			8
9	21 Office Salary	Direct Cost			698,886	698,886		7,681	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			238,998			1,045	10
11	22 Employee Benefits								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,942,124	\$ 3,501,860		\$ 22,992	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, LLC # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	29,510	1,687	1
2	03 Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	29,510	485	2
3	06 Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	29,510	1,774	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		29,510	489	4
5	10 Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	29,510	5,602	5
6	10a Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	29,510	262	6
7	12 Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	29,510	78	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		29,510	723	8
9	17 Administration Salary	Patient Days	1,764,895	42	337,043	337,043	29,510	5,636	9
10	21 Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	29,510	55,911	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		29,510	7,605	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,799,547	\$ 4,272,235		\$ 80,252	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Billable Income	2,073,579		138,556		627	42	1
2	02 Food	Billable Income	2,073,579		852,614		627	293	2
3	06 Maintenance	Billable Income	2,073,579		1,311		627		3
4	17 Administration	Billable Income	2,073,579		25,000		627	8	4
5	19 Professional Fees	Billable Income	2,073,579		8,170		627	2	5
6	20 Dues & Subscriptions	Billable Income	2,073,579		2,312		627	1	6
7	21 Office & Clerical	Billable Income	2,073,579		53,285		627	16	7
8	24 Travel & Seminar	Billable Income	2,073,579		68,680		627	21	8
9	32 Interest Expense	Billable Income	2,073,579		571		627		9
10	35 Rent - Equipment & Auto	Billable Income	2,073,579		13,336		627	4	10
11	39 Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		627		11
12	01 Dietary - Salary	Billable Income	2,073,579		268,554	268,554	627	81	12
13	07 Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		627	11	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,582,287	\$ 268,554		\$ 479	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 149,712	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 149,712	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, LLC # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$ 3,728	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation						19,139	3
4	04 LAUNDRY	Direct Allocation						27,580	4
5	06 REPAIRS & MAINTENANCE	Direct Allocation						3,464	5
6	10 NURSING	Direct Allocation						51,271	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation						1,864	10
11	39 ANCILLARY	Direct Allocation						27,709	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 134,754	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle Bank		X	Mortgage			\$		\$ 2,678,111			\$ 94,464	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	LaSalle Bank		X	Line of Credit								6,562	6
7	Alloc from Care Centers		X									8,102	7
8	See Supplemental Schedule								160,232				8
9	TOTAL Facility Related						\$		\$ 2,838,343			\$ 109,128	9
	B. Non-Facility Related*												
10													10
11	Interest Income											(2,379)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$		\$			\$ (2,379)	14
15	TOTALS (line 9+line14)						\$		\$ 2,838,343			\$ 106,749	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Genesis (prior owners)						\$	\$ 160,232			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital							160,232				14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lakewood Nursing & Rehab Center, LLC**# **0046169** Report Period Beginning: **02/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2002 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ (2,239)	2
3. Under or (over) accrual (line 2 minus line 1).			\$ (2,239)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 47,813	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 45,574	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	13,481	8	
	1999	49,663	9	
	2000	51,450	10	
	2001	52,662	11	
	2002	45,196	12	

2003 Accrual is estimated based on a 5% increase in 2002 tax		13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
Care Centers (Allocation) = \$1,148		14	PLUS APPEAL COST FROM LINE 5	\$	14
The credit on line 2 represents a credit from the prior owners for January 03 of \$3,387 less CCI allocation of \$1,148		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>68,681.49</u>	\$ <u>1,148.39</u>
2. <u>06-03-10-312-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>45,196.04</u>	\$ <u>45,196.04</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>113,877.53</u>	\$ <u>46,344.43</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 15,925
 B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 77,062
 2. Number of Years Over Which it is Being Amortized:
 various

3. Current Period Amortization:
 10,123
 4. Dates Incurred:
 2003

Nature of Costs:
 Organization Costs, Loan Closing Costs, Settlement, HUD Appraisal

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	273,121	2003	\$ 237,379	1
2	Alloc from 2201 Main LLC			8,501	2
3	TOTALS	273,121		\$ 245,880	3

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10								-		-	9
11								-		-	10
12								-		-	11
13								-		-	12
14								-		-	13
15								-		-	14
16								-		-	15
17								-		-	16
18								-		-	17
19								-		-	18
20								-		-	19
21								-		-	20
22								-		-	21
23								-		-	22
24								-		-	23
25								-		-	24
26								-		-	25
27								-		-	26
28								-		-	27
29								-		-	28
30								-		-	29
31								-		-	30
32								-		-	31
33								-		-	32
34								-		-	33
35								-		-	34
36								-		-	35

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,155,716	50,056		50,056		50,056	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		32,154	1,075		1,075		1,145	68
69	Financial Statement Depreciation			747			(747)		69
70	TOTAL (lines 4 thru 69)		\$ 2,187,870	\$ 51,878		\$ 51,131	\$ (747)	\$ 51,201	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,187,870	\$ 51,878		\$ 51,131	\$ (747)	\$ 51,201	1
2	Water Heater	2003	4,980		20	187	187	187	2
3	Roof Repairs	2003	750		20	22	22	22	3
4	Tile Repair	2003	1,012		20	30	30	30	4
5	Security System	2003	2,803		20	70	70	70	5
6	Hot Water Heater	2003	4,719		20	118	118	118	6
7	A/C Repair	2003	760		20	13	13	13	7
8	Hot Water Repair	2003	786		20	13	13	13	8
9	Hot Water Repair	2003	2,632		20	44	44	44	9
10	Plumbing Repair	2003	1,650		20	21	21	21	10
11	Fire Alarm Control Panel Repair	2003	557		20	7	7	7	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,208,519	\$ 51,878		\$ 51,656	\$ (222)	\$ 51,726	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		2003		\$ 2,127,169	\$ 48,748		\$ 48,748	\$	\$ 48,748	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements		2003		28,547	1,308		1,308		1,308	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,155,716	\$ 50,056		\$ 50,056	\$	\$ 50,056	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9		
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	2201 Main LLC			2002	\$ 11,714	\$ 293		\$ 293	\$	\$ 317	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	2201 Main LLC allocation			2002	10,847	542		542		588	9	
10	2201 Main LLC allocation			2003	9,593	240		240		240	10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 32,154	\$ 1,075		\$ 1,075	\$	\$ 1,145	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 21,827	\$ 1,585	\$ 1,585	\$	10	\$ 18,047	71
72	Current Year Purchases	155,166	20,768	13,503	(7,265)	10	13,503	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 176,993	\$ 22,353	\$ 15,088	\$ (7,265)		\$ 31,550	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Center allocation			\$ 11,264	\$ 1,225	\$ 1,225	\$	5	\$ 1,225	76
77	Care Center allocation			917	92	92		5	92	77
78										78
79										79
80	TOTALS			\$ 12,181	\$ 1,317	\$ 1,317	\$		\$ 1,317	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,643,573	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,548	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,061	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,487)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 84,593	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Off-Site Storage				702			5
6	Allocation from Care Centers				1,901			6
7	TOTAL				\$ 2,603			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 8,921

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 49,730	\$		\$ 49,730	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			14,775			14,775	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			287,843			287,843	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				181,171		181,171	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						51,434		51,434	13
14	TOTAL			\$		\$ 352,348	\$ 232,605		\$ 584,953	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 80,769	\$ 89,150	1
2	Cash-Patient Deposits	1,900	1,900	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	863,695	863,695	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,674	15,674	6
7	Other Prepaid Expenses	3,726	3,726	7
8	Accounts Receivable (owners or related parties)	181,381	15,697	8
9	Other(specify): See Attached Schedule	216,879	276,989	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,364,024	\$ 1,266,831	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		2,127,169	14
15	Leasehold Improvements, at Historical Cost	17,289	45,836	15
16	Equipment, at Historical Cost	31,941	155,734	16
17	Accumulated Depreciation (book methods)	(10,028)	(10,028)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		551,140	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		24,666	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 39,202	\$ 3,131,896	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,403,226	\$ 4,398,727	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 248,129	\$ 248,129	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,700	1,700	28
29	Short-Term Notes Payable		160,232	29
30	Accrued Salaries Payable	149,719	149,719	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,115	11,115	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,813	47,813	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	278,678	278,678	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 737,154	\$ 897,386	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,678,111	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,678,111	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 737,154	\$ 3,575,497	46
47	TOTAL EQUITY (page 18, line 24)	\$ 666,072	\$ 823,230	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,403,226	\$ 4,398,727	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	666,072	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 666,072	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 666,072	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,869,057	1
2	Discounts and Allowances for all Levels	(1,410,593)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,458,464	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,337,188	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,337,188	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,362	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	185,599	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,464	19
20	Radiology and X-Ray	6,730	20
21	Other Medical Services	69,708	21
22	Laundry	7,187	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 323,050	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,379	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,379	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,121,081	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	731,360	31
32	Health Care	1,907,186	32
33	General Administration	828,901	33
	B. Capital Expense		
34	Ownership	330,066	34
	C. Ancillary Expense		
35	Special Cost Centers	610,902	35
36	Provider Participation Fee	46,594	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,455,009	40
41	Income before Income Taxes (line 30 minus line 40)**	666,072	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 666,072	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 02/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,877	1,968	\$ 60,837	\$ 30.91	1
2	Assistant Director of Nursing	1,483	1,555	40,141	25.81	2
3	Registered Nurses	16,128	17,547	427,149	24.34	3
4	Licensed Practical Nurses	15,092	15,807	322,651	20.41	4
5	Nurse Aides & Orderlies	55,157	59,756	708,598	11.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,690	4,473	76,437	17.09	8
9	Activity Director	1,730	1,870	35,937	19.22	9
10	Activity Assistants	2,998	3,225	23,729	7.36	10
11	Social Service Workers	4,421	4,695	78,700	16.76	11
12	Dietician					12
13	Food Service Supervisor	1,826	1,964	38,442	19.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,757	15,379	136,775	8.89	15
16	Dishwashers					16
17	Maintenance Workers	4,090	4,524	66,122	14.62	17
18	Housekeepers	10,671	11,584	89,926	7.76	18
19	Laundry	3,874	4,321	35,869	8.30	19
20	Administrator	1,917	2,094	75,837	36.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,767	5,426	56,798	10.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,520	1,873	23,457	12.52	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	144,998	158,061	\$ 2,297,405 *	\$ 14.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	106	\$ 4,811	01-03	35
36	Medical Director	monthly	9,700	09-03	36
37	Medical Records Consultant	monthly	3,440	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,790	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	384	11-03	44
45	Social Service Consultant	7	399	12-03	45
46	Other(specify)				46
47					47
48	<u>CCI - see attached</u>		11,506		48
49	TOTAL (lines 35 - 48)	121	\$ 33,030		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, LLC

0046169

Report Period Beginning: 02/01/03

Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%		Description	Amount	Description	Amount	
Kath Dyhouse (2/1-2/28/03)	Administrator	0	\$ 9,631	Workers' Compensation Insurance	\$ 89,483	IDPH License Fee	\$ 278	
Sue Brune (2/14-12/31/03)	Administrator	0	66,206	Unemployment Compensation Insurance	43,653	Advertising: Employee Recruitment	1,494	
				FICA Taxes	164,119	Health Care Worker Background Check (Indicate # of checks performed <u>108.5</u>)	2,169	
				Employee Health Insurance	83,835	Dues & Subscriptions	1,990	
				Employee Meals		Licenses & Fees	1,142	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotion	10,327	
						Alloc from Care Centers Inc	593	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,837	Employee Physical	2,848			
B. Administrative - Other				Misc Employee Welfare	228			
				Christmas Expense	2,610			
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	(10,327)	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 386,776	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,666	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount
Vendor/Payee	Type						Out-of-State Travel	\$
Frost, Ruttenberg & Rothblatt	Accounting		16,500					
TBT Enterprises	Unemployment Consult		412				In-State Travel	
Meyer Magence	Legal		1,704					
CT Corporation	Legal		191					
Neal, Gerber & Eisenberg	Legal		1,732					
Care Centers Inc.	Bookkeeping Service		12,648				Seminar Expense	1,159
ADP	Payroll Processing		4,330				Allocation from Care Centers Inc.	393
National Datacare	Data Processing		295					
Sitebuilders	Data Processing		11				Entertainment Expense	()
Care Centers Inc.	Professional Fees		1,200				(agree to Sch. V, line 24, col. 8)	
Care Centers Inc.	Home Office Expense		61,380				TOTAL	\$ 1,552
See Supplemental Schedule			2,913					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 103,316	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

STATE OF ILLINOIS

0046169

Report Period Beginning:

02/01/03

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,096 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 46,594
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.